

The Assisted Human Reproduction Act
and
LGBTQ Communities

**A paper submitted by the
AHRA / LGBTQ Working Group**

March, 2008

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We are a group of Toronto-based service providers (physicians, nurses, fertility counselors, midwives, community development workers, lawyers), researchers (university, institutional, community-based), and consumers of reproductive technologies who, between us, have decades of experience working with and on behalf of LGBTQ (lesbian, gay, bisexual, trans, queer) individuals and communities.

We are collectively connected to thousands of LGBTQ people who are planning families, often involving the use of AHR technologies. Some fertility clinics estimate that as much as 30% or more of their clients are members of LGBTQ communities (statistic cited by Toronto-based fertility clinics at joint session of Dykes Planning Tykes/Daddies & Papas 2B, 2007). As such, we have followed with keen interest the development of the AHRA and see ourselves, our clients, and the communities of which we are a part as key stakeholders in the implementation and enforcement of the Act.

Below we have compiled some of our key concerns and recommendations in relation to the Act, including our input on the two areas for which regulations are currently being written. We would be most willing to discuss any of this further. We welcome this opportunity to inform you about the needs, issues and concerns of LGBTQ communities who are accessing reproductive technologies and look forward to keeping you abreast of issues as they develop in our communities.

Counselling

Understanding Context

With regards to counselling, it is very important to understand the context within which LGBTQ people make use of AHR services. We appreciate the acknowledgement on page one of Health Canada's Public Consultation Document on Counselling Services under the Assisted Human Reproduction Act that "not all users of AHR services experience infertility (e.g. same-sex couples)" and the use of the term AHR counselling, as opposed to "infertility counselling." The context in which we make use of AHR services is key to understanding how our counselling needs differ from those of heterosexual consumers. For us, AHR services are often our first stop on the road to conception. Although, of course, some of us do experience fertility challenges, for the most part we use AHR in order to access sperm and egg donations. The psychological issues discussed on page two of the Counselling document – guilt, anger, shame and depression – are most often not the issues we are grappling with. In fact, the stress and anger that we experience is most often due to lack of awareness and sensitivity to our particular circumstances and communities on the part of service providers at fertility clinics and sperm banks. As one of our clients noted recently, when asked about her

experiences with a fertility clinic, “we need counselling to get over the counselling we are given.” Our biggest hurdle, when accessing AHR services, is overcoming the systemic homophobia/transphobia and heterosexism we so frequently encounter in the health care system. The expectation that our particular circumstances will not be addressed or understood in a counseling situation was stressed by a participant in a recent study: “My doctor at one point said, ‘you might want to access the fertility counsellor,’ but I haven’t because I know that the majority of clients they serve are straight.” (Appendix A - Ross, Steele, & Epstein, 2006a) (See also CLGRO 1995; 1997).

Much counselling also focuses on questions of how and when to disclose the use of AHR technologies to the children conceived by these methods. Again, these issues are experienced very differently by our communities. For the most part, for obvious reasons, disclosure is not a choice for us – most of us tell our children from the start about how they were conceived. Many LGBTQ communities also share a history and a culture that values and promotes honesty and truth-telling generally, and, in this case, in particular with regards to children and child-rearing. Too many of us have suffered as young people from secrets we were forced to keep and/or from silences that denied our experience. We do not want to impose secrets and/or silences on our children.

As well, there is a history of gate-keeping in relation to counselling of LGBTQ people. In very recent history some Canadian fertility clinics required psychiatric assessment of lesbians before they were granted access to donor insemination services. We also know of at least one Toronto physician who required lesbians requesting access to donor insemination to write a “letter to the doctor” in order to convince him that they should be granted access to services. Other clinics and physicians simply denied access to lesbians and single women.

The public consultation document on Counselling Regulations acknowledges that the requirements for counselling might not be the same for everyone. We strongly suggest that the counselling requirements for LGBTQ communities be explicitly non-gate-keeping, non-mandatory, widely available and culturally competent.

Non-Gate-Keeping Counselling

The current Act is unclear whether the outcomes of counselling could be used to deny access to service. We strongly feel that if this is the case, it needs to be made explicit, together with detailed criteria upon which decisions to deny access to AHR services would be made. Considering the historical denial of access to AHR and other services to LGBTQ people and other marginalized groups, it is essential that any criteria upon which AHR services would be denied be made public such that our group and other groups have the opportunity to provide feedback. The Act includes a non-discrimination policy. What does this mean in terms of any criteria that could be used as the basis on which to deny service?

Non-Mandatory Counselling

The process of conception for lesbians, trans men and some bisexual women is most often, by necessity, a thoughtful and planned process. We very rarely have unexpected or unplanned pregnancies. More often we spend years thinking about and planning our pregnancies. One 2003 study (Beatens, Camus, & Devroey) found that close to 70% of lesbian couples had discussed their desire for a child for 1 – 4 years before beginning the donor insemination process; another 11.46% had discussed the topic for more than 4 years. The process of planning our pregnancies also involves careful decision-making about known and unknown sperm donors, about methods of conception, and about family configurations. Because so much thought typically goes into our family planning, a mandatory counselling requirement can seem superfluous and unnecessary.

However, while the above historical and current context makes it difficult for us to endorse mandatory counselling, we do recognize the complexity of the issues related to some AHR services and therefore would recommend that people making use of complex AHR processes (eg. surrogacy) be strongly encouraged to access counselling as part of their decision-making process. That said, “counselling” and who can legitimately provide it, need to be clearly and broadly defined and, for our communities, carried out by individuals and/or organizations that are deeply familiar with LGBTQ communities and issues, i.e. that are “culturally competent.”

Widely Available Counselling

We appreciate the AHR Act’s guiding principle of free and informed consent, and the Royal Commission’s definition of informed choice as “providing relevant and understandable information about the options and the possible implications of various decisions.” (*Final Report of the Royal Commission on New Reproductive Technologies*, 1993)

People in our communities who are accessing AHR services do require reliable and easily accessible information about the AHR services we make use of and about the practical and ethical implications of our choices. Many of us may choose to do some form of psycho-educational counselling. In the spirit of informed choice, we therefore recommend that information and counselling be made available to all of us prior to the use of AHR services.

In terms of who can provide counselling, we strongly disagree with any provision that limits counseling to “mental health professionals.” Our communities have a history of stigmatization and pathologization by mental health professionals, and these are therefore not necessarily the people we turn to for assistance. As well, it is crucial to recognize that information and counselling can come in many different forms. Many of us access information and/or counselling from GPs, midwives, nurses, social workers, community workers, and/or mental health counsellors, and from courses, workshops and materials

offered in some communities (i.e. Dykes Planning Tykes; Daddies & Papas 2B; manuals, brochures, etc.) Any of these are valid forms of counselling for LGBTQ people.

Most significant for us when it comes to the receiving of information and/or counselling, is that the people and/or services providing it understand the histories, cultures and experiences of LGBTQ people and communities. As stated above, the stress and anger that we experience in relation to our use of AHR services most often stems from a lack of this knowledge on the part of the service providers we encounter. Recent research has found that the need clearly exists for AHR service providers who are knowledgeable about the varied issues that lesbian and bisexual women experience in relation to AHR services (Appendix B - Ross, Steele, Epstein, 2006b). Therefore, most critical to us, is that people offering education and counselling in relation to our use of AHR services are culturally competent.

Culturally Competent Counselling

At its inception in 2001 the LGBTQ Parenting Network held a series of focus groups to inquire about the priorities of LGBTQ parents and prospective parents. Near the top of identified needs was the need for “LGBTQ-positive” professionals. Defining what makes a “LGBTQ-positive” professional is not simple; it requires a deep level of knowledge translated into behaviours and practices that recognize and acknowledge the histories, cultures and values of LGBTQ communities. This is what is sometimes referred to as “cultural competency.”

“Culture” is defined as the totality of socially transmitted behaviour patterns, arts, beliefs, customs, celebrations, and history. Although some may debate the existence of a LGBTQ culture, there clearly exists a shared set of attitudes and behaviours, art, celebrations, and a history of oppression for these communities. Systems of care that are culturally competent not only recognize the importance of culture in our daily lives but are cognizant of the dynamics created by cultural differences and are adaptive to the needs of different cultures.

The term “cultural competency” refers to a long-term developmental process that moves beyond “cultural awareness” (the knowledge about a particular group primarily gained through media resources and workshops) and “cultural sensitivity” (knowledge as well as some level of direct experience with a cultural group other than one’s own). Cultural competency is an engaging, life-long journey of expanding your horizons, thinking critically about power and oppression, and behaving appropriately. Culturally competent individuals have a mixture of beliefs/attitudes, knowledge/experience, and skills that help them to establish trust/rapport and communicate effectively with others. (See Appendix C, “What is Cultural Competency?”)

LGBTQ people have suffered for decades at the hands of service providers whose assumptions, attitudes and practices do not recognize their unique experiences and cultures. For this reason, we raise this as the most pressing of issues in relation to the Counselling regulations currently being developed. If those providing information and/or

counselling are not culturally competent, LGBTQ consumers of AHR services will continue to be unacknowledged, marginalized and, in some cases, actively discriminated against, in the process of attempting to access services.

Reimbursement of Expenditures under the *Assisted Human Reproduction Act*

As a group we endorse the Canadian Bar Association's recommendations on this subject (September, 2007). Please see Appendix D for their full report and recommendations.

Other Issues for LGBTQ communities with regards to the AHR Act:

1. Criminalization of home insemination

Since the AHR Act was enacted, there have been concerns in LGBTQ communities about the potential criminalization of home insemination under the Act. We have consistently raised this concern at briefing sessions and patient/consumer workshops and have been reassured by Health Canada that this is not the intent of the Act and that home inseminations would be exempted from the provisions that apply to "controlled activities." We have on several occasions, in person and by email, requested that we receive this reassurance in writing, and/or that it be posted on the Health Canada website, in order to reassure the people we work with that this is the case. We have been told that this is forthcoming but, to date, have not received anything. A simple letter clarifying the intent of the Act would go a long way to calming the fears of many in our communities, including service providers who are unclear about how to advise clients.

2. The right to take sperm home

Related to (1) above, here again it is important to understand the context within which we access sperm banks and fertility clinics. Most of us approach sperm banks and fertility clinics, not because we are dealing with fertility issues, but simply as a way to access sperm in order to conceive. Many of us, given the choice, would prefer to inseminate in the comfort and intimacy of our own homes, rather than in a more clinical setting. To this end, we would like a process developed by which we can either have sperm shipped to our homes and/or are able to take sperm home from a physician's office or fertility clinic. The process would, of course, involve our assuming the liability for any risks involved.

3. Insemination with a known donor who is not a sexual partner

Currently, if a woman (or trans man) approaches a fertility clinic with a man who is identified as a sexual partner, she/he can request insemination with his sperm without freezing and without the 6 month quarantine. If a woman (or trans man) approaches the clinic with a man who is identified as a known sperm donor, she/he is required to have his sperm frozen for 6 months before it can be accessed and is required to pay for this process. While we understand that the intent of this practice is to protect people from undetected risks, in fact there are no fewer risks in being inseminated with the sperm of

someone one is having sex with, than there is being inseminated with the sperm of a known donor one has been inseminating with. The risks are the same. If one is willing to assume the risk of insemination from a sexual partner, one should also be able to assume the risks of insemination from a known donor.

The situation outlined above has put people who are using known sperm donors in the position of lying when they approach fertility clinics. If they present their donors as sexual partners, they can access the services they require. If they tell the truth, they are denied. As well this means that in the case of a lesbian couple, the non-birth parent is left out of the process, which results in undue hardship to her. She is left out of the very personal and significant process of her child's conception.

We would like to see a process developed by which people can assume the responsibility and the risks for insemination with the fresh sperm of a known donor.

4. Use of gay men as sperm donors

Related to (2) above, with regards to our rights to use the donors of our choice, is the issue of gay men as sperm donors. We are aware that this has been challenged twice in court, to no avail, but continue to be concerned that in order to use a "gay man," i.e. a man who has sex with men, as a sperm donor, we have to go through a different and costly process in order to get special permission from Health Canada. The policy is steeped in the homophobic and discriminatory view that "gay" men are synonymous with HIV/AIDS, and a lack of separation of identity from sexual practice. Again, we would like to see processes developed by which we can assume the responsibilities and the risks of using the donor of our choice.

5. Consistency and transparency of costs

We hear many reports of users of fertility clinics having a difficult time getting accurate and consistent information about fees. For example, one research participant indicated: "They would charge \$100 extra per unit (of sperm) and they would say (to her friend) it was for syringes. And (to a different friend) they said it was GST and PST...it was really shady, and that was probably the biggest stress for me." (Ross, Steele, Epstein, 2006a)

Hidden and unpredictable costs, including pressure to order sperm through a clinic when it is less expensive for users to order sperm directly from sperm banks, contribute to frustration and a feeling of exploitation from people accessing AHR services (Ross, Steele, Epstein, 2006b).

We would like a process developed by which fertility clinics and sperm banks are required to fully disclose and publish all fees associated with all procedures.

6. Awareness of LGBTQ issues and concerns reflected in all documents and practices related to the operation of fertility clinics and sperm banks

Finally, we would like to reiterate what a significant client population we represent. As mentioned above, some fertility clinics estimate that as many as 30% or more of their clients are from LGBTQ communities. We would like to see awareness of this presence reflected throughout the AHRA regulations, and in the language, documents, sensibility and practices of sperm banks and fertility clinics. For example, acknowledgement of our presence would include:

- Staff that are trained to be culturally competent in relation to LGBTQ communities - to be aware of and sensitive to the needs, concerns and sensibilities of LGBTQ clients, including the specific needs of trans-identified clients.
- Intake and procedure forms that explicitly make room for family configurations that do not assume male/female relationships, or a 2-parent model – i.e. that recognize the sometimes complex family configurations that LGBTQ people, and others, are forming.
- Involvement of all parties desired by patients, including partners, known sperm donors and co-parents.
- Language and treatment that recognizes that LGBTQ people are often accessing fertility clinics and sperm banks as part of routine family planning, and not as infertility clients. Provide opportunities for women to make informed choices about interventions that are consistent with their known or presumed infertility.
- Cues that services are LGBTQ positive. These might include positive space imagery or posters and brochures depicting LGBTQ families. Individual service providers can provide cues that they are open to LGBTQ families through choice of gender-neutral language, and attention to the ways that questions are posed.
- Information available about local LGBTQ services, supports and resources. Where feasible offer LGBTQ-specific services or services in partnership with LGBTQ communities and/or service providers.
- Expand the selection of donor semen, particularly with respect to donors of diverse ethnocultural origins and open identity donors.
- Strive for a unified standard of care across geographic regions, and facilitate access for people living outside of major urban centres.

Signed, respectfully,

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Ross, L, Steele, L, & Epstein, R. (2006b) Lesbian and bisexual women's recommendations for improving the provision of assisted reproductive technology services. *Fertility and Sterility*. September; 86(3), 735-738.

Appendices

Appendix A: Ross, L., Steele, L, & Epstein, R. (2006a) Service Use and Gaps in Services for Lesbian and Bisexual Women During Donor Insemination, Pregnancy, and the Postpartum Period. *Journal of Obstetrics & Gynaecology Canada* . June. 505-511.

Appendix B: Ross, L, Steele, L, & Epstein, R. (2006b) Lesbian and bisexual women's recommendations for improving the provision of assisted reproductive technology services. *Fertility and Sterility*. September; 86(3), 735-738.

Appendix C: What is Cultural Competency?

Appendix D: Canadian Bar Association, September, 2007. Reimbursement of Expenditures under the *Assisted Human Reproduction Act*.

Glossary of Terms

Lesbian/Gay: Terms to describe individuals whose primary sexual and affectional attractions are to members of the same sex. It is common to refer to men as gay and women as lesbian.

Bisexual: An individual who is attracted to people of either sex or gender.

Transsexual: A term for people who feel internally that they are of the opposite sex and gender to that in which they were socialized from birth. Transsexuals may undergo surgery and/or hormone therapy in order to make their bodies fit what they feel is their true sex and gender.

Transgender: A term for people who cross gender norms but may choose not to modify their bodies medically. People who identify as transgender may identify as and express a gender that does not match their biological sex, or may not embrace binary gender systems at all.

Queer: A term that has traditionally been used as a derogatory and offensive word for LGBTQ people. Many have reclaimed this word and use it proudly to describe their identity and/or as an umbrella term for LGBTQ people or communities.

Homophobia/Biphobia: Prejudice against (fear or dislike of) lesbian, gay and bi individuals, and behaviours based on this prejudice.

Heterosexism: The assumption that everyone is and should be heterosexual and that heterosexuality is the only normal form of sexual expression for mature, responsible human beings. Systemic policies and practices that favour heterosexual individuals and couples over LGBTQ individuals and couples; a frame of mind or world view that holds heterosexuality at its core.

Transphobia (or less commonly, ***transprejudice***) refers to discrimination against transsexual or transgender people, based on the expression of their internal gender identity; the negative valuing, stereotyping and discriminatory treatment of individuals whose appearance and/or identity does not conform to the current social expectations or conventional conceptions of gender.

Dykes Planning Tykes: A 12-week, Toronto-based course for lesbian/bi/queer women who are considering parenthood.

Daddies & Papas 2B: A 12-week, Toronto-based course for gay/bi/queer men who are considering parenthood

Lesbian and bisexual women's recommendations for improving the provision of assisted reproductive technology services

Qualitative focus groups were conducted with lesbian and bisexual women who were themselves or whose partners were in the process of trying to conceive ($n = 6$); who were biological parents of young children ($n = 7$); and who were nonbiological parents of young children or whose partners were currently pregnant ($n = 10$) to explore their donor insemination service needs and to provide recommendations for improved or additional services. The 10 recommendations generated by participants included providing cues that the service is lesbian and bisexual positive; offering lesbian- and bisexual-specific infertility support; providing opportunities for women to make informed choices about use of interventions consistent with their known or presumed fertility; and offering accessible services to known sperm donors, including gay men. (Fertil Steril® 2006;86:735–8. ©2006 by American Society for Reproductive Medicine.)

A significant number of women choose to have children through donor insemination after identifying themselves as lesbian or bisexual (1). Many of the needs of lesbian and bisexual women who access assisted reproductive technologies (ARTs) will be similar to those of heterosexual women. However, lesbian and bisexual women may wish to be inseminated by a man who is known to them but is not their sexual/intimate partner (e.g., a gay male friend or coparent) (2). For women in a same-sex relationship, both partners are potentially able to carry a child, and decision making may be necessary to determine who will be the childbearing mother (3). Finally, homophobia and heterosexism faced by lesbian and bisexual women may be an important determinant of their ability to access services (2).

To our knowledge, no published studies have specifically examined the service needs of lesbian and bisexual women in relation to ART. As increasing numbers of lesbian and bisexual women choose to access ART, services developed primarily for heterosexual women will need to be assessed to determine the extent to which they

are useful for and accessible to lesbian and bisexual women. With this goal in mind, we report on findings from focus groups with lesbian and bisexual parents and prospective parents with respect to their experiences utilizing services for donor insemination.

Three focus groups were conducted between November 2003 and January 2004 in Toronto, Canada. Participants were a volunteer sample of 23 women who identified their sexual orientation as other than heterosexual, and were either the childbearing or nonchildbearing mother of a child less than 3 years of age, an expectant mother, or a prospective mother (i.e., in the process of trying to conceive). Demographic characteristics of the sample are available from the first author. All participants gave written informed consent to participate, and the local institutional review board approved the research.

In each semistructured focus group, participants were asked to discuss experiences they found to be stressful or positive during preconception, pregnancy, and parenting, and experiences using health or social services during preconception, pregnancy, and parenting. This article focuses on the results pertaining to experiences with ART services only. We present the themes in the format of recommendations for the provision of ART to lesbian and bisexual women, which are also summarized in Table 1.

Recommendation 1
Involve all parties desired by patients, including partners, known sperm donors and coparents. Many lesbian and bisexual women wish their partners to be involved in the donor insemination process to as great an extent as possible. Some women choose to conceive with a known sperm donor or male coparent, and in some cases, this person may attend clinic appointments and should be included in care if

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The opinions, results, and conclusions are those of the authors, and no endorsement by the Ontario Ministry of Health and Long-Term Care is intended or should be inferred.

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Summary of recommendations

1. Involve all parties desired by patients, including partners, known sperm donors, and coparents.
2. Provide accessible fertility services for known sperm donors, including gay men.
3. Expand the selection of donor semen, particularly with respect to donors of diverse ethnocultural origins and open-identity donors.
4. Minimize costs for services and communicate a consistent fee structure.
5. Provide opportunities for women to make informed choices about interventions consistent with their known or presumed fertility.
6. Offer infertility support that is specific to lesbian and bisexual women (e.g., specialized groups) or is provided by individuals who are knowledgeable about issues relevant to lesbian and bisexual women.
7. Provide cues that the service is lesbian and bisexual positive.
8. Strive for a unified standard of care across geographic regions, and facilitate access for women living outside of major urban centers.
9. Where feasible, offer specialized services or services in partnership with the lesbian and gay community.
10. Help lesbian and bisexual women to connect with other relevant services and support systems.

Ross. ART service needs of lesbians. *Fertil Steril* 2006.

the woman desires. Direct inquiry about all parties to be involved in conception and/or parenting will help to determine who should be included in a care plan.

Recommendation 2

Provide accessible fertility services for known sperm donors, including gay men. Known sperm donors are often gay male friends or acquaintances of the prospective mothers. Presently, in Canada, women face several barriers to using a known gay sperm donor. An application to government must be made by a physician before a woman can be inseminated with semen from such a donor. Further, when the sperm donor is not the patient's sexual partner, Health Canada requires that the semen be tested and quarantined for 6 months before it can be used for insemination, creating a significant delay. Finally, women are required to pay the costs of testing and storage of a known donor's sperm, which are often prohibitive.

Recommendation 3

Expand the selection of donor semen, particularly with respect to donors of diverse ethnocultural origins and open-identity donors. Participants who were not Caucasian or wished to use an identity-release donor expressed dissatisfaction with the limited selection of donor semen available. Although many heterosexual women may also desire more culturally diverse, and perhaps to a lesser extent, open-identity donors, the limited donor pool presents unique challenges for lesbian and bisexual women because of the small and interconnected nature of this community: Friends or acquaintances might choose to use the same sperm donor, leading to difficult questions about whether to disclose this information to their friends, and eventually, to their children.

Recommendation 4

Minimize costs for services and communicate a consistent fee structure. The cost of donor semen was a significant barrier and a substantial stress for many participants, despite the fact that in Ontario, insemination services are covered under the provincial health plan. Presently, the cost of semen for donor insemination in Toronto ranges from approximately \$700–\$950 Canadian dollars (\$635–\$865 US dollars) per cycle. The inconsistency in costs, both between and within sperm banks, created additional stress for participants. Some reported feeling exploited in that they perceived sperm banks to charge more than necessary to cover the costs associated with collecting the sperm. The lack of transparency and consistency in billing contributed to participants' sense of frustration.

Recommendation 5

Provide opportunities for women to make informed choices about interventions that are consistent with their known or presumed fertility. Lesbian and bisexual women who use frozen donor sperm are often required to access fertility clinics targeted primarily toward heterosexual women who have been unable to conceive without the aid of ART. Interventions are often offered to all clinic patients, including lesbian and bisexual women with no known fertility problems. Although some women welcomed these interventions, others were uncomfortable with the medicalization of what they perceived to be a natural process. Some women may feel that they are not given the choice to decline suggested tests or procedures, particularly due to their already vulnerable status as service users. Open discussion about the benefits and risks of potential interventions will provide women with the opportunity to make informed choices.

Recommendation 6

Offer infertility support that is specific to lesbian and bisexual women (e.g., specialized groups) or is provided by individuals who are knowledgeable about issues relevant to lesbian and bisexual women.

One participant in this study had known fertility problems, and two others had been trying to conceive for extended periods without achieving pregnancy. Although these women all felt they could benefit from emotional support, they reported that they either would not access or were dissatisfied with fertility support services offered through their fertility clinics because they were targeted toward heterosexual women. Lesbian and bisexual women face unique issues, including having to decide whether to switch sperm donors if there is no evidence of their own infertility, having their partner be the childbearing mother if they themselves are unable to conceive or carry to term, and in some cases, feelings of internalized homophobia that may surface in relation to fertility problems.

Recommendation 7

Provide cues that the service is lesbian and bisexual positive.

Some participants described the environment at their fertility clinic as uncomfortable or unwelcoming. Women perceived that the staff did not want to know any more than necessary about their lives and relationships, and therefore these women felt uncomfortable divulging personal details or asking questions. Steps toward creating a more visibly welcoming environment may include displaying positive space imagery or posters depicting lesbian and gay families. Individual service providers can also provide cues that they are open to lesbian families through choice of gender-neutral language during assessments. Diversity in sexual orientation should also be reflected in clinic forms. Many clinics use standard forms that will be inappropriate for lesbian and bisexual patients, among others who do not conform to the traditional two-parent family.

Recommendation 8

Strive for a unified standard of care across geographic regions, and facilitate access for women living outside of major urban centers.

Participants from outside of Toronto reported additional barriers to accessing ART. Finding a supportive health care provider was challenging for women from small, underserved or conservative communities. In some cases, health professionals acted as gatekeepers, creating additional barriers not required by Canadian law (and presumably not applied to heterosexual women) before they would offer ART. For example, one physician in a small town required a police check and a social work home study before providing ART to an openly identified lesbian. Some women attempted to avoid these barriers by traveling to Toronto; however, the limited hours of fertility clinics (offering cycle mon-

itoring only between 7:00 AM and 9:30 AM) often made this impossible for women living more than an hour drive out of town.

Recommendation 9

Where feasible, offer specialized services or services in partnership with the lesbian and gay community.

Participants indicated a desire for insemination services targeted specifically to lesbian, gay, and bisexual families (e.g., offered through a gay and lesbian primary care clinic). In many communities, specialized services will not be feasible due to a small population of lesbian, gay, and bisexual prospective parents. In these cases, services could be offered in collaboration with other healthcare providers serving the lesbian and gay communities (e.g., offering cycle monitoring in collaboration with midwifery clinics or family physicians known to the community).

Recommendation 10

Help lesbian and bisexual women to connect with other relevant services and supports.

Many participants reported the value of accessing information and support systems specifically for lesbian and bisexual parents, such as the “Dykes Planning Tykes” course, a program for lesbian and bisexual prospective parents offered in downtown Toronto. Service providers could familiarize themselves with such resources in their communities in order to make referrals.

CONCLUSIONS

The results of this study have identified a number of domains in which lesbian and bisexual women perceive room for improvement in the provision of ART. Many of the recommendations proposed could have implications for other patients using ART, regardless of their sexual orientation. For example, inclusion of all desired parties in the provision of care will be appreciated not only by lesbian and bisexual women, but also by others who plan to parent outside of a heterosexual two-parent family, including single heterosexual women. Striving to ensure that services are accessible to women living outside of major urban centers will benefit many heterosexual women. In each of these cases, however, lesbian and bisexual women are likely disproportionately affected by the current standard of care due to the unique biological and social context of lesbian parenting.

This study is limited by the small, volunteer sample, and by collection of data from only one site (Toronto). As a result of these limitations, results may not generalize to the broader community of lesbian and bisexual women accessing ART, and additional studies are needed to confirm the results.

Lesbian and bisexual women may fear discrimination as a result of their sexual orientation, and as a result, may feel unable to articulate any dissatisfaction with services for fear that the services will be withdrawn and they will be left without other options for achieving pregnancy. A proactive approach is therefore required to understand and respond to their needs. Additional research is needed to systematically assess uptake of and satisfaction with ART by lesbian and bisexual women.

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Service Use and Gaps in Services for Lesbian and Bisexual Women During Donor Insemination, Pregnancy, and the Postpartum Period

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Abstract

Objective: Increasing numbers of lesbian and bisexual women are choosing to have children. This qualitative study investigated the degree to which a sample of Canadian lesbian and bisexual women were satisfied with the health and social services that they received during the process of trying to conceive, during pregnancy, and during the early postpartum weeks and months.

Methods: Three focus groups were conducted: (1) women who were themselves, or whose partners were, in the process of trying to conceive (n = 6); (2) biological parents of young children (n = 7); and (3) women who were non-biological parents of young children or whose partners were currently pregnant (n = 10). Participants were asked to discuss their positive and negative experiences with health and social services during their efforts to conceive and through the perinatal period.

Results: Participants were very satisfied with the care they received from midwives, doulas, and public health nurses. Services directed specifically to lesbian, gay, and bisexual parents were also perceived to be important sources of information and support. Many participants perceived fertility services to be unsupportive or unable to address their different health care needs.

Conclusion: Participants expressed satisfaction with pregnancy-related services provided by non-physicians and dissatisfaction with services provided by physicians and fertility clinics. There is a strong desire for fertility services specific to lesbian and bisexual women, but even minor changes to existing services could improve the satisfaction of lesbian and bisexual patients.

Résumé

Objectif : De plus en plus de femmes lesbiennes et bisexuelles choisissent d'avoir des enfants. La présente étude qualitative s'est penchée sur le degré de satisfaction d'un échantillon de Canadiennes lesbiennes et bisexuelles envers les services sociaux et de santé dont elles ont bénéficié au cours de leur

tentative de concevoir, au cours de la grossesse, ainsi qu'au cours des premières semaines et des premiers mois à la suite de l'accouchement.

Méthodes : Trois groupes de discussion ont été menés : (1) femmes tentant elles-mêmes de concevoir ou dont la partenaire tentait de le faire (n = 6); (2) parents biologiques de jeunes enfants (n = 7); et (3) femmes étant les parents non biologiques de jeunes enfants ou dont la partenaire était alors enceinte (n = 10). Nous avons demandé aux participantes de discuter de leurs expériences positives et négatives en ce qui a trait aux services sociaux et de santé au cours de leurs efforts visant la conception et tout au long de la période périnatale.

Résultats : Les participantes ont été très satisfaites des soins qu'elles ont obtenu de la part de sages-femmes, de doulas et d'infirmières de santé publique. Les services visant particulièrement les parents lesbiens, gais et bisexuels ont également été perçus comme étant d'importantes sources de renseignements et de soutien. Bon nombre de participantes ont perçu que les services de fertilité ne leur offraient pas de soutien ou n'étaient pas en mesure de répondre à leurs besoins particuliers en soins de santé.

Conclusion : Les participantes ont exprimé avoir été satisfaites des services de grossesse offerts par des professionnels n'étant pas des médecins et insatisfaites des services offerts par les médecins et les cliniques de fertilité. L'offre de services de fertilité s'adressant particulièrement aux femmes lesbiennes et bisexuelles est grandement souhaitable; cependant, l'apport de modifications mineures aux services existants aurait suffire à améliorer la satisfaction des patientes lesbiennes et bisexuelles.

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INTRODUCTION

Many lesbian and bisexual women have or wish to have children.¹ Although some have had children in previous heterosexual relationships, a significant number of women choose to have children either through adoption or donor insemination after identifying themselves as lesbian or bisexual.^{2,3}

Through the process of insemination, pregnancy, and parenting, the service needs of lesbian and bisexual women

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will often be similar to those of heterosexual women. However, there are significant ways in which the family context of lesbian and bisexual women differs from heterosexual women, and these differences may have implications for service delivery. For example, lesbian and bisexual women may wish to be inseminated by a man who is known to them but is not a sexual or intimate partner (e.g., a gay male friend or co-parent).³ For women who are in a same-sex relationship, both partners are often potentially able to carry a child, and they must decide which woman will be the biological mother.⁴ During pregnancy and the postpartum period, services developed primarily for heterosexual fathers may not be accessible to or useful for non-biological lesbian mothers.⁵ Homophobia and heterosexism faced by lesbian and bisexual women in their daily lives may be an important determinant of their need for and ability to use health care services. Anticipated or actual discrimination by health care professionals may also determine the extent to which lesbian and bisexual mothers take up pre-conception and perinatal health services.^{3,6}

A growing body of evidence has shown lesbians have lower rates of access to general health care services despite having higher rates of health behaviours that put them at risk for illness (including smoking, alcohol use, and obesity).^{7,8} Although little research has investigated the reasons for lack of general health care access, lesbian, gay, and bisexual populations are believed to face personal and cultural barriers to access that lead to delays in seeking care and preventive services. Barriers include the fear of disclosing sexual orientation to providers, a lack of cultural competency among health care providers, and a lack of appropriate services.⁹ Even less research has been done to explore health and social service use by lesbian and bisexual women during donor insemination and the perinatal period. One early survey of 35 lesbian mothers found that participants were generally satisfied with their obstetric care, although women who used midwives for care reported higher levels of support and satisfaction than did women who used physicians.¹⁰ A more recent study combined qualitative and quantitative methods to describe the maternity care experiences of a volunteer sample of 50 lesbian mothers in the UK. In this study, although the majority reported overall satisfaction with their maternity care, problems were noted, particularly in relation to disclosure of sexual orientation to providers and to heterosexism in antenatal classes.¹¹

To our knowledge, no published studies have examined the satisfaction of Canadian lesbian and bisexual women with the health and social services related to pre-conception and the perinatal period. Providers of fertility, obstetrical, and postpartum care have a responsibility to assess how useful and accessible these services will be for the increasing

number of lesbian and bisexual women who choose to use them. With this goal in mind, we report on findings from three focus groups with lesbian and bisexual parents and prospective parents about their experiences using health and social services for pre-conception and perinatal care.

METHODS

Three focus groups were conducted at a downtown Toronto community health centre between November 2003 and January 2004. Toronto has a large and diverse lesbian, gay, bisexual, and transgender and transsexual (LGBTT) community, including a significant number of LGBTT parents. There are also several small suburban and rural communities close to Toronto, which enabled us to include participants receiving services both in downtown Toronto and in smaller communities.

Participants were recruited primarily via email flyers distributed through key contact people and listservs for the LGBTT and parenting communities in Toronto and the surrounding area. Paper copies of flyers were also distributed to local community health centres and women's centres. Interested participants self-referred for the study by telephone or email. They were then screened by telephone to determine their eligibility. In order to be eligible, participants were required (1) to identify themselves as lesbian, gay, bisexual, transgender, transsexual, or two-spirited (see Table for definitions), and (2) to be the biological or non-biological mother of a child less than three years of age, to be an expectant biological or non-biological mother (i.e., one partner being currently pregnant), or to be a prospective biological or non-biological mother (i.e., one partner trying to conceive). Adoptive parents, bisexual women parenting with male partners, and parents of children older than three years were excluded from the focus groups, since they were anticipated to have service needs different from the target participants.

Focus groups were each 1.5 hours in length and were facilitated by the first author (LER). The groups were semi-structured and in each group participants were asked to discuss three primary subject areas. This paper focuses on the results for one of these subject areas: the experiences of participants using health or social services during pre-conception, pregnancy, or parenting. Although the same discussion guide was followed for all three focus groups, its application was flexible and allowed participants to define and discuss other topics they felt were relevant to their experiences.

Written informed consent was obtained from each participant before the focus groups. The protocol was approved by the local Institutional Ethics Review Board.

Definitions of relevant terms

Lesbian/gay	"Lesbian/gay": Terms to describe individuals whose primary sexual and affectional relationships are with members of the same sex. The term gay is sometimes used to refer to either men or women, although it is becoming more common to refer to men as gay and women as lesbian.
Bisexual	"Bisexual": An individual who is attracted to people of either sex or gender.
Transsexual	"Transsexual": A term for people who feel internally that they are of the opposite sex and gender to that in which they were socialized from birth. Transsexuals may undergo surgery and/or hormone therapy in order to make their bodies fit what they feel is their true sex and gender.
Transgender	"Transgender": A term for people who cross gender norms but may choose not to modify their bodies medically. People who identify as transgender may identify as and express a gender that does not match their biological sex, or may not embrace binary gender systems at all.
Two-spirited	"Two-spirited": Some Aboriginal traditions recognize three or four different genders. Two-spirited people are Aboriginal individuals who identify as being of both male and female genders. Two-spirited identity is not exclusively about sexuality but is about physical, mental, emotional, and spiritual expression and experience. Two-spirited people may identify this way based on gender identity or sexual orientation.
Biological mother/non-biological mother	The term "biological mother" refers to a woman who bears a child, and "non-biological mother" refers to the intimate partner of a woman who bears a child, who is involved in parenting that child. Other terms synonymous with non-biological mother that have been used in the literature on lesbian families include "co-mother" and "social mother."
Homophobia	"Homophobia": prejudice against (fear or dislike of) LGBTT individuals and behaviour based on this prejudice.
Heterosexism	"Heterosexism": systemic policies and practices that favour heterosexual individuals and couples over LGBTT individuals and couples; a frame of mind or world view that holds heterosexuality at its core

LGBTT: lesbian, gay, bisexual, transsexual, transgender

Focus groups were tape-recorded and transcribed verbatim. After the accuracy of the transcripts had been verified by the facilitator, they were entered into the qualitative text management software package QSR N6 (QSR International Pty Ltd, 2002, Melbourne, Australia) and analyzed using thematic content analysis. Data from the three focus groups were coded into a number of themes; these themes primarily emerged from the data but were also informed by existing literature. Following the coding procedure, the text under each node was summarized into an analytic theme memo.

RESULTS

A total of 23 women participated in this study: six women participated in the focus group for prospective LGBTT parents, seven women participated in the focus group for biological mothers, and 10 women participated in the focus group for non-biological mothers or expectant non-biological mothers. All of the participants had intimate partners at the time of the focus groups. Participants had a mean age of 33.6 years (range 22–43 years). Participants who were trying to conceive had been doing so for a range of one month to more than two years. The mean age of the

youngest child was 6.2 months for parents in the biological parents group and 11.9 months for parents in the non-biological parents group. Two women in the non-biological parents' focus group had partners who were pregnant at the time of the interview. Eighteen (78%) of the participants identified as lesbian, with the remaining participants identifying as gay, bisexual, two-spirited, or queer. Eighteen (78%) of the participants were Caucasian, two (9%) were Aboriginal, two (9%) Black Canadian, and one (4%) South Asian. Seventeen of the participants were parenting or planned to parent solely with a partner, two were parenting with a partner and an involved known donor, two were parenting or planned to parent with a partner and other close family and community members, one intended to parent with a co-parent not her partner, and another planned to be the sole parent of her child.

Three main categories of text related to services were extracted from the data: (1) experiences with pre-conception care; (2) experiences with care during pregnancy; and (3) experiences with postpartum services and support.

Pre-Conception Care

Some participants, especially those already parenting, reported being very satisfied with their experiences of medically assisted donor insemination. Some participants used donor insemination services through sperm banks and were pleased with the care they received there. However, most of the focus group discussion about donor insemination and fertility services highlighted negative experiences the women had in the process of trying to conceive. In particular, both non-biological parents and prospective parents were largely dissatisfied with the care they had received from these services, as described below.

High Cost of Semen and Semen Processing

The cost of services associated with donor semen for insemination was described as a significant barrier and stressor for many participants in all groups. At present, the cost of obtaining cryopreserved donor semen in Toronto ranges from about \$700 to about \$950 per cycle. Perceived inconsistency in costs, both between and within sperm banks, created additional stress for participants as they struggled to understand the fees. Some women in the pre-conception group discussed their belief that sperm banks charge much more than is necessary to recover their costs. Women perceived a lack of transparency and consistency in billing that contributed to their sense of being exploited financially:

They would charge \$100 extra per unit [of sperm] and they would say [to her friend] it was for syringes. And then [to a different friend] they said it was GST and PST. . . . It was really shady, and that was probably the biggest stress for me.

Another area where financial barriers were noted was in access to testing of semen from known donors for cryopreservation. The cost of testing, processing, and storing semen from known donors is at least as high as the cost of purchasing semen from anonymous donors and can often be higher:

We thought about using a sperm bank, but because we wanted to use a known donor, it was just financially impossible. Because if you're using a known donor, and using the sperm just for yourself, you have to pay all the costs associated with him donating the sperm and it ends up being . . . some crazy number.

Limited Donor Selection

Participants expressed frustration with the limited selection of donors available through sperm banks. This was particularly an issue for women who were not Caucasian or whose partners were not Caucasian and who wanted their child to share their ethnocultural background:

I'm Métis and my partner is First Nations, and we've been trying to do an unknown donor, which is almost

impossible, because sperm banks don't keep First Nations people because of their backgrounds of diseases like heart disease and diabetes . . . so that's been the most trying part because neither one of us wants to raise a child that is not ethnically connected to us.

Some participants were also disappointed with the small number of identity-release donors available (i.e., donors who are willing to have their identity released to the child when the child reaches the age of 18):

When you go to the sperm bank, you can choose someone who is okay with being known in the future or being contacted in the future, and there are so few donors that are willing to do that, that it's limited. And we didn't end up going that route, but that's really what we would have preferred.

Barriers Related to Sexual Orientation

Participants reported barriers to specific fertility services as a consequence of their sexual orientation or that of their donors. This was particularly true for some participants living outside Toronto who were required to undergo a home study and police check before being permitted access to fertility services. Participants who wanted to use a known sperm donor did not have access to insemination services for their proposed donor through their sperm bank or fertility clinic if he had been sexually active with men. In that case, special permission from Health Canada was required, followed by a six-month quarantine period. Most women saw the resulting delay as prohibitive. All participants who were having difficulty conceiving reported that they either would not use or were dissatisfied with fertility clinic counselling services because these services were designed for heterosexuals:

My doctor at one point said, "You might want to access the fertility counsellor," but I haven't because I know that the majority of clients they serve are straight.

Finally, some participants described the environment at their fertility clinics as uncomfortable for lesbian and bisexual women. In some cases, women had the impression that their fertility clinics were serving them not because they wanted to help lesbian and bisexual women form families, but because the clinic staff felt they had no other choice.

The Medicalization of Conception

Those women who used cryopreserved sperm had used insemination services in clinics that primarily dealt with infertility. Many of these women reported that multiple medical interventions (e.g., bloodwork, ultrasound examinations, medication) were often the norm. Some women welcomed these interventions, which they saw as helping them to conceive more quickly, but others were

uncomfortable with the “medicalization” of what they perceived to be a natural process:

I think because at the clinic they are used to dealing with people with fertility problems, it's almost like you got treated as a fertility problem from day one instead of just somebody who wanted to get pregnant. So they had all these tests and stuff that they would do, and I guess we could have said no, but we are also thinking that we want to make sure that it's going to go as smoothly as possible.

LGBTT-Specific Services

Women who were trying to conceive agreed that insemination services developed specifically for LGBTT families would be extremely helpful. Participants reported a desire for a sperm bank with a pool of donors of diverse ethnocultural origins and for access to semen analysis and sexually transmitted infections testing for known donors who are gay.

Many participants reported using information and support services designed specifically for LGBTT parents. In particular, several women had participated in the “Dykes Planning Tykes” course, a program for lesbian and bisexual prospective parents offered through a community centre in downtown Toronto. Some participants living outside Toronto reported either travelling into Toronto to take the course, or making use of the course “textbook.” Participants reported that the course was helpful, not only for the information it provided, but also for the support network it enabled them to create involving other women who shared many of their experiences.

Legal barriers to conception

As noted above, special permission from Health Canada is required for Canadian health care providers to process and distribute donor sperm from a man who has had sex with men. The women in our study often chose gay men to be donors, and these women therefore faced additional barriers to testing and insemination services that were more readily available to other women. Canadian regulations also require that donor inseminations with cryopreserved sperm occur under the supervision of a physician. It may be difficult for women who wish to use cryopreserved sperm to find the appropriate medical services. Finding health professionals who would perform inseminations was a particular challenge for women living outside downtown Toronto:

There are some laws that offer a very oppressive framework for lesbians trying to use fertility clinics to become pregnant. And some clinics have worked hard to work under that framework and still provide good services, but a lot of clinics are not making an effort and use some of the laws as an excuse.

Women faced uncertainty regarding the parental rights of same-sex families should a known donor later petition for custody or access to the child. As a result of this uncertainty, many women felt it was necessary to establish a contract with their donor before insemination. Usually, legal services were needed, which became very expensive since the donor and each partner were required to have separate legal counsel:

We had a very, very long contract drawn up with [the donor] . . . and we were told that although it shows intention, it will really not stand up in court; that it will be interpreted in the best interest of the child, and that may or may not be what we want. So that was pretty stressful. And plus, the lawyers tried to split us up at every path. So every time we drew up a contract, they would send our donor off to get another lawyer, and me off to get another lawyer, and to try at any point to make that contract as a couple rather than two individuals is very hard.

Care During Pregnancy

Prenatal Classes

Some participants reported positive experiences with their prenatal education. For example, in some cases there were other same-sex couples in the classes, and participants had the opportunity to discuss their shared experiences. However, many participants reported heterosexism in their prenatal classes, particularly with regard to the use of exclusive language:

I thought that the language was exclusive to a lot of people. It was, “you and your husband, you and your husband.” Well, there are single people here; there are people who aren't married. She'd keep correcting herself after the fact—“I mean partner, whatever.” . . . No, it's not whatever.

Obstetric Care

Participants reported only positive experiences with care from midwives and doulas. Indeed, one participant described midwifery care as “the best health care we ever got”:

We were planning a home birth but ended up having to go to the hospital, and [the midwife] was a dream at the hospital. I think that she helped shepherd this lesbian couple through things. The nurses were good, but I think that she cleared the way. We had one offensive doctor . . . she dealt with him in a really efficient way.

Participants were pleased with midwives, not only for the health care they provided, but also for their willingness to act as patients' advocates in interactions with other health care providers. For some participants, primary care

providers and gynaecologists also acted as advocates, for example, referring them to hospitals or fertility clinics that they knew to be more accepting of lesbian families. Negative experiences with obstetric services tended to occur when participants encountered hospital staff with whom they did not have a pre-existing relationship, or when hospital policies did not account for same-sex family structures:

There was no connection there to my partner, whereas, I think if we were a straight couple, they would have been more looking at my husband . . . so I don't know if it was the fact of the actual birth plan, or the fact that we were a same-sex couple, or because we said this is what we want to do—we were getting some resistance from the staff.

From the very first day when [her daughter] was born, we're in the hospital, and they give us the wrist bands. . . and the wrist bands say "mother," and the other one says "father," right on the wristband. And I thought, couldn't you just give us two "mother ones, is that going to confuse everybody too much?

Postpartum Services and Support

Participants reported using few services for postpartum support. Most support after the birth seemed to be provided by informal sources such as friends and family members. However, one participant described a very positive experience with a public health nurse who visited the home to provide postpartum support.

After childbirth, most participants used the legal system to complete the process of second-parent adoption. In Ontario, a non-biological mother must adopt her child through second-parent adoption before she can have a legally recognized parental relationship. Because Canadian law currently states that a child cannot have more than two legal parents, lesbian couples who have an involved sperm donor must consider carefully whether that donor will waive his legal rights to the child, enabling the non-biological mother to become a legal parent. A legal clinic was the service participants in the focus group for non-biological parents wanted most. This was suggested as a program that could be offered as part of a family health centre.

Participants who were non-biological parents reported some problems using pediatric and child care services. In particular, participants reported that some pediatric and child care service providers were unwilling to recognize the non-biological mother as a legitimate parent.

DISCUSSION

This is the first study to focus on the experiences of Canadian LGBTT women who are trying to conceive, who

are pregnant, or who are newly parenting, in their use of public services. Participants in our study faced added challenges in the process of trying to conceive that were often directly related to their sexual orientation or the sexual orientation of their chosen donor. Positive experiences were reported in relation to care in pregnancy delivered by midwives and doulas. After childbirth, participants tended to be supported by accepting family and friends rather than the health system. The challenges facing participants who were new parents were most often legal challenges related to parental rights.

Like many qualitative studies, this study is limited by a small, mostly Caucasian, volunteer sample. Results may not generalize to the broader community of lesbian and bisexual women using pre-conception and perinatal health care. Although transgender and transsexual women were eligible to participate in this study, we were unsuccessful in recruiting transgender or transsexual women with children younger than three years of age. Further research that focuses on the transgender and transsexual communities would be valuable.

CONCLUSION

There are several simple steps that providers can take to improve the delivery of existing services to the LGBTT population and to reduce barriers to care. Health care providers who offer fertility services can ensure that LGBTT women do not face hurdles to care, such as requirements for home studies or police checks, that heterosexual women do not face, and can ensure that clinic intake and hospital forms use language that is inclusive of different types of family structures, including same-sex partners. They could seek to include women's partners and, if requested, women's sperm donors or co-parents in discussions related to conception and childbirth. Care providers can become knowledgeable about LGBTT-positive health services that are available in their community and facilitate their patients' referral to these services. Finally, they can advocate for federal and provincial policies that will establish the provision of assisted reproductive services that are accessible, equitable, flexible, and cost-efficient.

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What is Cultural Competency?

“Culture” is defined as the totality of socially transmitted behaviour patterns, arts, beliefs, customs, celebrations, and history. Although some may debate the existence of a LGBT culture, there clearly exists a shared set of attitudes and behaviours, art, celebrations, and a history of oppression for these communities. Systems of care that are culturally competent not only recognize the importance of culture in our daily lives but are cognizant of the dynamics created by cultural differences and are adaptive to the needs of different cultures.

The term “cultural competency” refers to a long-term developmental process that moves beyond “cultural awareness” (the knowledge about a particular group primarily gained through media resources and workshops) and “cultural sensitivity” (knowledge as well as some level of direct experience with a cultural group other than one’s own). Cultural competency is an engaging, life-long journey of expanding your horizons, thinking critically about power and oppression, and behaving appropriately. Culturally competent individuals have a mixture of beliefs/attitudes, knowledge/experience, and skills that help them to establish trust/rapport and communicate effectively with others.

With regard to beliefs/attitudes, the culturally competent individual is:

- Aware of and sensitive to her/his own cultural heritage and also respects and values different heritages
- Aware of her/his own values and biases and how they may affect the perception of other cultures
- Comfortable with differences that exist between her/his culture and other cultures’ values and beliefs
- Sensitive to circumstances (personal biases, ethnic identity, political influence, etc.) that may require seeking assistance from a member of a different culture when interacting with another member of that culture

With regard to knowledge, the culturally competent individual must:

- Demonstrate good understanding of the power structure in society and how non-dominant groups are treated
- Acquire specific knowledge and information about the particular group(s) s/he is working with
- Recognize institutional barriers that prevent members of disadvantaged groups from using organizational and societal resources

With regard to skills, the culturally competent individual must:

- Generate a wide variety of verbal and nonverbal responses (body language) when communicating with individuals of different backgrounds or culture
- Send and receive both verbal and nonverbal messages accurately and appropriately
- Intervene appropriately and advocate on behalf of individuals from different cultures (i.e., serve as an ally)



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APPENDIX D

Reimbursement of Expenditures under the *Assisted Human Reproduction Act*

CANADIAN BAR ASSOCIATION

September 2007

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PREFACE

The Canadian Bar Association is a national association representing 37,000 jurists, including lawyers, notaries, law teachers and students across Canada. The Association's primary objectives include improvement in the law and in the administration of justice.

This submission was prepared by the National Health Law and Family Law Sections and the Sexual Orientation and Gender Identity Conference of the Canadian Bar Association, with assistance from the Legislation and Law Reform Directorate at the National Office. The submission has been reviewed by the Legislation and Law Reform Committee and approved as a public statement of the Canadian Bar Association.

Reimbursement of Expenditures under the *Assisted Human Reproduction Act*

I. BACKGROUND

The Canadian Bar Association [CBA] welcomes the opportunity to comment upon the consultation document “Reimbursement of Expenditures Under the *Assisted Human Reproduction Act*” (consultation document). The *Assisted Human Reproduction Act* (AHRA) provides a regulatory and licensing framework for assisted reproductive technologies and establishes governing principles for its application.

As the first federal legislative effort to regulate this area, the AHRA is important to all Canadians. However, the approach of the legislation, to prohibit certain activities and criminalize non-compliance, may have adverse affects on some individuals. In particular, the prohibition against compensating gamete donors and surrogates is likely to have an ongoing negative impact on the availability of assisted reproductive technologies for Canadian women and men who choose to use fertility services. For those who want access to fertility agencies, traveling to the United States for these services involves significant additional cost and inconvenience. Prohibition may also inadvertently encourage informal arrangements made without the benefit of legal advice.

The CBA has contributed at various stages in the development of laws pertaining to assisted human reproduction.¹ In 2001, we noted the ongoing evolution of views in this area, and the likelihood that social attitudes, concerns and public perceptions of assisted reproductive technologies would continue to change over time. The CBA said that a regulatory body could best keep pace with the latest scientific, ethical, legal and social information, and

¹ For example, Submission of the Canadian Bar Association to the Royal Commission on New Reproductive Technologies (Ottawa: CBA, 1990); Submission on Bill C-47, *Human Reproductive and Genetic Technologies Act* (Ottawa: CBA, 1997); Submission on Draft Legislation on Assisted Human Reproduction

educate and inform the public about emerging controversies that could impact regulatory policy.

The AHRA begins with a declaration of principles that gives priority to the health and well-being of children born through assisted reproductive technologies. It emphasizes that human reproductive capacities should not be exploited for commercial ends, and that women are more directly and significantly affected by these technologies than men. The declaration of principles also acknowledges the benefits of assisted human reproductive technologies for individuals, families and society in general.

While the availability of fertility services impacts all segments of the population, limits to that availability are likely to systemically discriminate against single people, and the lesbian, gay, bisexual and transgendered communities, who more often rely on assisted reproductive technologies to have children. The governing principles of the AHRA also explicitly recognize that persons who undergo assisted reproduction procedures must not be discriminated against on the basis of sexual orientation or marital status.

Since the CBA's earlier submissions and the enactment of the AHRA, the demand for assisted reproductive technologies has indeed grown and use of those technologies become more common and widely accepted. Given the protections contained in the AHRA and its governing principles, we believe that regulations should impose additional obstacles on prospective parents only if required to respond to evidence of abuse or exploitation.

In light of these observations, we believe that regulations pertaining to controlled activities pursuant to section 12 of the AHRA should be broad enough to not further detrimentally impact the availability of surrogates or gamete donors.² This will help to ensure that the benefits of assisted reproduction procedures are available to all Canadians who seek reproductive assistance.

(Ottawa: CBA, 2001); Letter to the B. Brown, M.P., Chair – Commons Standing Committee on Health, Bill C-56, *Assisted Human Reproduction Act* (Ottawa: CBA, 2002).

² However, we recognize that as the use of reproductive technologies becomes more prevalent, there may be unanticipated costs beyond those borne directly by prospective parents. For example, there may be demands for legal aid or for children's advocates if impecunious donors or surrogates wish to challenge an arrangement.

II. PROPOSALS FOR REGULATIONS AND LICENSING RELATING TO REIMBURSEMENT OF EXPENSES

The consultation document proposes certain categories of expenses that should be available for different controlled activities. Part A of the consultation document proposes categories of receipted expenditures eligible for reimbursement, and a formula for reimbursement of loss of income for surrogate mothers.

The consultation document appropriately does not suggest a defined cap on expenditures, as that would artificially impose the same or similar treatment on diverse situations. We agree that there should be a mechanism for approving expenditures not listed so as to ensure that any expenditure appropriately fits within the meaning of the AHRA. The CBA also supports the requirement that the expenses in the circumstances be reasonable. However, in every gamete donation and surrogacy situation, different circumstances arise requiring various different expenditures. For example, the prospective parent(s) may choose or be required to use a surrogate in a different province, making travel expenses greater than for a local surrogate.

We believe that the categories of expenditures should not be exhaustive. The proposed categories of expenditures should include, but not be limited to the categories set out in the consultation document. There will always be reasonable expenditures incurred in the process of gamete donation or surrogacy arrangements that cannot be anticipated in advance. Each particular situation is unique. Provided the regulations require expenses to be reasonable, they should not attempt to define all categories of reasonable expenses exhaustively. The regulations should not unduly restrict the categories but should only provide guidance as to what might be reasonable expenses in a typical surrogacy situation.

III. EXPENDITURES RELATED TO SPERM DONATION

In our view, independent legal services should be an additional category outlined in the non-exhaustive list of categories of expenses in Part A. There is no significant body of Canadian common law establishing the rights and obligations of a donor, and it is reasonable and prudent for gamete donors to obtain independent legal advice with respect to those rights and obligations. In practice, donors regularly consult with lawyers in making arrangements

and preparing contracts, particularly where the donors are identified.

The suggested category of “health care services” indicates in parenthesis that the services must be “provided and prescribed by health care providers”. In our view, health care services should be specifically defined in the regulations to include both traditional and alternative health care providers. In addition, we believe that health care services should be eligible for reimbursement whether or not they are “prescribed”. Otherwise, the requirement would unduly fetter the reasonable decision of intended parents and donors who wish to use health care services or alternative therapies that may increase fertility rates, whether or not those services can be “prescribed”.

IV. EXPENDITURES RELATED TO OVA DONATION

The previous comments with respect to independent legal services and health care services should also apply to ova donation. It is common practice for clinics to require ova donors to have independent legal advice before donating. In addition, ova donors’ health care services should be reimbursed whether they represent alternative therapies or are recommended by “prescribed health care providers”.

Ova donation requires many medical appointments and at least one day of lost employment for retrieval. The legislation and proposal for regulations do not expressly allow for loss of work-related income for ova donors. While the AHRA allows for loss of work-related income for surrogate mothers, it is silent with respect to ova donation. Ova donors should be entitled to reimbursement for loss of work-related wages for medical appointments and attendances for retrieval.

V. EXPENDITURES RELATED TO SURROGACY

The categories set out in the consultation document for expenditures related to surrogacy are, in our view, far too narrow. Again, the list should not be exhaustive. In addition to the categories proposed in the consultation document, we suggest the following:

1. Personal Food Consumption: Surrogates are frequently asked to refrain from a diet high in processed foods, and to instead adopt one high in fiber and nutrients, often requiring organic foods. Such food is commonly more expensive than processed food.
2. Household help: A pregnant surrogate may need assistance in her last trimester, whether or not she faces health conditions related to the pregnancy. This is particularly true where multiple births are involved.
3. Childcare: This should be available whenever the surrogate needs relief, and not only when she needs to attend a scheduled appointment. Childcare should not be conditional upon medical advice.
4. Appliances for pregnancy: Some examples of appliances commonly used during pregnancy are pillows, foot rests or varicose vein hosiery.
5. Vitamins and supplements.
6. Yoga classes or gym membership.
7. Life insurance: In practice, almost all intended parents obtain life insurance in the event of a death of the surrogate to provide for the surrogate's next of kin.
8. Communication costs: land lines and cell phones. Intended parents should bear the cost of communication with the surrogate.

VI. EXPENDITURES FOR MAINTENANCE OF *IN VITRO* AND TRANSPORTATION OF *IN VITRO* EMBRYOS

Independent legal services should also be available for parties incurring expenditures relating to maintenance, transportation and donation of embryos. In addition, cryopreservation and storage fees should be reimbursable for the entire time that the embryo is cryopreserved. Any regulation should not unduly limit reimbursement for these expenses.

VII. REIMBURSEMENT OF LOSS OF WORK-RELATED INCOME FOR SURROGATES

The proposal in the consultation document would allow reimbursement for loss of work-related income for surrogates only where a qualified medical practitioner certifies in writing that there is a risk to the surrogate's health or to the health of the embryo fetus. We believe that the loss of work-related income for surrogates should be defined in a manner that would capture legitimate "sick days" or time taken off work due to the pregnancy, even though there may not be a direct "risk" to the surrogate's health or that of the embryo fetus. For example, extreme morning sickness may not be a health risk, but may be such that the

surrogate is unable to work. That absence would be a direct consequence of her surrogacy, and she would lose work-related income.

In addition, a pregnant woman can start to collect Employment Insurance maternity benefits as early as eight weeks before her anticipated due date, without a certificate from a doctor. This suggests that the federal government recognizes that pregnant women may well have health-related needs in the last two months of pregnancy. In our view, intended parents should be able to supplement a surrogate's income during the EI maternity benefit period.

The definition should be sufficiently broad to allow reimbursement for loss of work-related income for any absence directly connected to the pregnancy. Otherwise, the surrogate would be subsidizing the costs of the surrogacy. While the legislation formally seeks to promote and support the altruistic aspects of surrogacy, this would actually penalize women for offering to embark on a gestational carrier arrangement.

With respect to the particular proposal for reimbursement of loss of work-related income, the CBA notes that the model proposed in the regulations presumes that the surrogate is employed when she offers to become a surrogate. However, many surrogates have children of their own and may have been on parental leave prior to commencing a surrogacy. Others may have been unemployed or choose not to return to work to become a surrogate for a friend or family member. Also, it is an unfortunate reality that women may still not be hired on the basis of their pregnancy. The model for reimbursement of loss of work-related income should be broad enough to address special circumstances that warrant payment for loss of work-related income as a reasonable expense, while ensuring that the expense is not simply compensation for surrogacy. The formula set out in the regulations should be sufficiently flexible to capture special circumstances.

VIII. LICENSING RELATING TO REIMBURSEMENT OF EXPENSES

The consultation document proposes that those who may reimburse a surrogate for expenses are limited to the child's intended parents. However, in our view, there may be many other parties, including partnerships, health care teams, associations, family health care teams or

surrogacy consultants who should be able to obtain a license to reimburse the surrogate. Prior to the AHRA, third parties were frequently used to reimburse surrogates for expenditures, and to determine the reasonableness of expenditures in accordance with contracts between the parties. When the AHRA was proposed, the CBA noted the breadth of its prohibition against third party intermediaries, and recommended that certainly doctors, lawyers and psychologists should be available to assist in surrogacy arrangements.³

The current proposal appears to suggest a significant policy change by prohibiting anyone other than the intended parents to administer the reimbursement of surrogate mothers and to assess what are reasonable expenses in accordance with legislative requirements. Given the realities and the demand for third parties to assist prospective parents with surrogacy arrangements, we believe that this restriction is too narrow.

In practice, surrogates frequently enter into contracts that provide for a maximum of eligible expenses to be paid. Third party surrogate consultants or agencies are often engaged to process these expenses much like an accountant would assess the reasonableness of an expense for tax purposes. These services determine the reasonableness of an expense in accordance with the legislation and the contracts between the parties, and reimburse the expense in a timely manner from an amount held in trust. Receipts are required and monthly transactional costs are negotiated. Negotiations directly between a surrogate and intended parents on the minutiae of expenses would be inefficient, cumbersome, and potentially even lead to conflicts. Accordingly, the CBA suggests it is unreasonable for the regulations to propose that licenses to reimburse the surrogate would be limited only to intended parents.

IX. QUALIFICATIONS OF CORPORATE APPLICANTS

Many entities other than corporations may want to apply for a license. Health care teams, family clinics, partnerships, and other entities may be appropriately licensed. The CBA recommends that the qualifications of “corporate applicants” be defined more broadly so that they may include other entities properly constituted or practicing in Canada.

³ *Supra*, note 1, 2002 at 2.

X. CONCLUSION

The CBA appreciates the opportunity to comment on the consultation document, and trusts that our comments will be helpful in improving the regulations.